# TREATMENT PLAN

**Confidential**

| **State of California** |
|---|
| **Treatment Plan** |
| VCGCB-VOC-6015 (Rev. 03-15-04) |

**California Victim Compensation and Government Claims Board**

Return Form To:

**Victim Compensation Program**
**P.O. Box 3036**
**Sacramento, CA 95812-3036**

Or Your Local Victim/Witness Assistance Center Verification Unit

| **Claim #** | **Date Form Sent** |
|---|---|
| **Victim's Name** | |
| **Claimant's Name** | |
| **Incident Date** | |

**The Victim Compensation Program (Program) has received an application or bill for mental health services. In order for the Program to verify the claimed loss and authorize payment, please complete this form and return it to the address above. Please answer the questions fully and complete the signature page at the end of document. Use additional pages if necessary. Failure to complete this form may result in a delay or denial of payment.**

In order for the Program to pay for services, the client's application must be found eligible and the Program must determine that treatment is necessary as a direct result of the crime. Additional information may be needed to verify eligibility for reimbursement, which may include session notes. If approved, this Treatment Plan will cover ten (10) additional sessions (after the initial five), for a total of 15 sessions. **No additional payments may be authorized beyond the initial five (5) session hours until a completed Treatment Plan has been submitted to and approved by the Program.**

For clients with a service limitation of 30 or 40 sessions, authorization for reimbursement of additional treatment requires submitting a completed **Treatment Progress Report. No additional payments may be authorized beyond the first 15 sessions until a completed Treatment Progress Report has been submitted to and approved by the Program.**

For reimbursement to be considered for clients beyond their total service limitations (15, 30 or 40 – depending on the type of victim), reimbursement for additional treatment requires the treating therapist to complete and submit an **Additional Treatment Plan. No additional payments may be authorized for sessions beyond a claim's limit until a completed Additional Treatment Plan has been submitted to and approved by the Program.**

**Outpatient Mental Health Benefit Service Limitations:**

| **40 Session Hours:** | **30 Session Hours:** | **15 Session Hours:** |
|---|---|---|
| Direct Victim (Minor) | Direct Victim (Adult); or<br>Direct Victim of Unlawful Sexual Intercourse [violation of PC § 261.5 (d)]; or<br>Derivative: Qualified Surviving Family Member of Homicide Victim or fiancé (fiancée) of homicide victim who witnessed the crime; or<br>Derivative: Eligible Primary Caretakers of Minor Direct Victims (Shared) | Derivative (All Others Eligible For Mental Health Counseling) |

**Session Calculation:**

| Individual/Family: 1 Session Hour = 1 Session | Group: 1 Session Hour = .5 (1/2) Session |
|---|---|

As required by law, the information requested by the Program must be returned to the Board **within ten (10) business days** and must be provided at no cost to the client, the Board, or local Victim/Witness Assistance Centers. The Program certifies that there is a signed authorization on file for the release of the information requested.

You must complete this form to request reimbursement for sessions beyond the initial 5 sessions. Complete all questions unless otherwise specified.

| 1. Name of Client | 2. Name of Victim |
|---|---|



Date Completed: _____

3. Client's Relationship to Victim: (If this person became a primary caregiver after the crime and had **no previous relationship** with the victim, please complete questions 1 through 10 AND 17 through 20 ONLY.)

| 4. Name of Therapist | 5. Provider Organization Name |
|---|---|

6. License/Registration Number and Expiration Date

7. Mark Appropriate Box for Title of Licensed/Registered Therapist (refer to #6)

| | |
|---|---|
| ☐ LMFT | ☐ LMFT Intern |
| ☐ LCSW | ☐ ASW |
| ☐ Licensed Clinical Psychologist | ☐ Registered Psychologist |
| ☐ Licensed Psychiatrist | ☐ Resident in Psychiatry |
| ☐ Psychological Assistant Intern | ☐ Other (Please specify): |

8. Name and Title of Supervising Therapist (If applicable)

| 9. License Number | 10. Expiration Date |
|---|---|

11. What is the client or caregiver's initial description of the crime for which you are providing treatment?

12. What are the client's presenting symptoms/issues (by your observation and client report)?

13. If this victimization was not recent, i.e., within the last 6 months, please describe what brought the client into treatment at this time.

14. Please evaluate this client with respect to the current **Diagnostic and Statistical Manual of Mental Disorders (DSM)** criteria. Evaluate on all 5 axes. Please complete this section as fully and accurately as possible.

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

15. **If this client is six years of age or older**, please evaluate him or her on the Social and Occupational Functioning Assessment Scale (SOFAS) that is discussed in the current DSM. (Note: Rate the relational unit in which he or she resided at the time of this report). Score: _____.

☐ Client is under 6 years of age.

Please describe your client's specific behaviors that support this rating:

16. Please evaluate the client on the Global Assessment of Relational Functioning (GARF) scale that is discussed in the current DSM. (Note: Rate the relational unit in which this client resided at the time of this report). Score: _____.

Please provide the basis that supports this rating:

17. Please identify any of the following factors that may interfere with the client's treatment.

| | No/Not Applicable | Yes |
|---|---|---|
| Mental status | ☐ | ☐ |
| Personal history | ☐ | ☐ |
| Support system | ☐ | ☐ |
| Justice system status | ☐ | ☐ |
| Family integrity | ☐ | ☐ |
| Economic/employment status | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

If you answered yes to any factors above, please explain.

18. What auxiliary services, e.g., collateral contacts (limited to no more than three sessions), medication management, social worker, school counselor, etc., will be involved during the treatment of your client?

19. If your client suffers from any physical and/or developmental disabilities, please note the nature and extent of each disability, any resources other than your treatment which the client may receive in connection with the disability, and show how the disability is reflected in your treatment plan.

☐ No disabilities

20. Are you aware of this client having any pre-existing condition or prior mental health treatment that may impact the current treatment? If so, please explain as fully as possible.

21. TREATMENT PLAN

Please state your goals for treatment and describe how you hope to accomplish these goals. Goals should be behavioral, observable and measurable. A **generic** treatment plan **will not be adequate**. If the client is a child, please indicate how the family members/caretakers will be involved in the treatment.

| Goals | Methods/Management | Progress Measurement | Number of Sessions to Reach Criterion |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |

**DECLARATION**

CLIENT NAME: _____ CLAIM NUMBER: _____

If the victim's offender is convicted, the Board will request the criminal court to order the offender to pay restitution to reimburse the Board for any expenses the Board has paid for this crime. As a treating therapist you must be prepared to testify in a restitution hearing that the mental health counseling services you provided were necessary at the percentage indicated below as a direct result of the crime.

A. In your opinion, what percentage of your treatment is necessary as a direct result of the qualifying crime?

- ☐ 0 %
- ☐ 25%
- ☐ 50%
- ☐ 75%
- ☐ 100%
- ☐ Other: _____%

B. What type of crime is the client being treated for?

Assault With a Deadly Weapon ☐ Domestic Violence ☐ Child Abuse/Molest ☐ Sexual Assault ☐ Robbery ☐ Hit and Run ☐

Driving Under the Influence ☐ Homicide ☐ Other (Do not include any confidential facts in your description of the crime.) ☐ _____

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form and, to the best of my information and belief, all my answers are true, correct and complete; and (2) all treatment submitted for reimbursement by the Board or pursuant to this form was necessary at the percentage noted above and as a direct result of the crime described above. I further understand that if I have provided any information that is false, intentionally incomplete or misleading, I may be found liable under Government Code section 12650 for filing a false claim with the State of California and/or guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

**I understand that mental health counseling treatment must be approved in advance. Approval for reimbursement is limited to no more than 15 sessions. Treatment beyond that number of sessions will not be reimbursed until approved. I understand that if treatment is provided without the required approval, the Program may not reimburse those expenses.**

**IMPORTANT – You MUST Provide The Required Signature(s) Below**

**Treating Therapist**:

Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

**If Registered Intern**:

Supervising Therapist's Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

**Tax Identification Number** of person or organization in whose name payment is to be made:

_____

If you would like to be contacted by email when possible, please enter your email address below (optional).

_____

Clear Form



Print